Patient Referral Form

Manhem IMPLANT CENTRE

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Referral Requirements (tick all that apply) Date: _____

- ☐ Dental Implants
- ☐ Bone Grafting
- ☐ Other Surgical Procedure Please Specify: _____

Implant System Preference (if relevant)

☐ 3i NT	☐ Astra	☐ Straumann Tissue Level
☐ 3i Prevail	☐ Nobel Replace	☐ Straumann Bone Level
☐ Ankylos	☐ Nobel Brånemark	☐ Xive

- ☐ Other Implant System _____
- ☐ No Implant System Preference

Required Procedure

- ☐ Surgical Procedure
- ☐ Surgical and Prosthetic Procedure

Referring Dentist Details

Name: _____

Address: _____

Postcode: _____ County: _____

Telephone: _____ Mobile: _____

Fax: _____ Email: _____

Patient Details

Name: _____

Date of Birth: _____ /_____ /_____ Gender: ☐ Male ☐ Female

Address: _____

Postcode: _____ County: _____

Telephone: _____ Mobile: _____

Fax: _____ Email: _____

Please Turn Over

Referral Information

(Please include reason for referral and specific problem areas)

I am sending: ☐ Study Models ☐ Digital Radiographs ☐ Film Radiographs

(Digital files may be sent by email to office@manhem.co.uk or on a disk, all other material shall be sent to 72 Harley Street, London, W1G 7HG. All Study Models and Film Radiographs will be returned after use.)

Relevant Medical History

Patient Medication

Patient Allergies